BHSF Form 1-CH
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II

LaCHIP
Louisiana Children's Health Insurance Program

For Agency Use Only
Request date_____ (Appl date) _____
Date mailed_____Agency Rep _____

To protect your application date, we must receive the application back by _____.

If you have questions or need help filling out this form, call us toll free at 1+877+2LaCHIP (252-2447).

What language do you speak best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify) _____
What language do you write best? ❑ English ❑ Spanish ❑ Vietnamese ❑ Other (specify) _____

This LaCHIP application is to get health benefits for children under age 19. **Do not** apply for anyone who already gets Medicaid. Please complete EVERY item on this form. If an item does not apply to you or your family, write "does not apply". If an answer to any question is none or 0, write "none". If more space is needed, use a separate sheet.

Where or how did you get this application form? **www.LaCHIP.org**
(Your answer will help us to learn the things we can do to help families find out about LaCHIP.)

Name of Parent or Person Applying _____Social Security Number _____
Mailing Address_____ City_____ State ___ Zip Code _____
Home Address_____ City_____ State ___ Zip Code _____
Parish_____E-mail Address _____
Home Phone # (____)_____ Cell Phone # (____)_____Other Phone # (____)_____
Best Day or Time to Call _____

1. Who are the **children** living in the home who need health coverage? Please include all children under age 19 that live in the home.

Name - First, Middle Initial, Last	Applying for coverage? Y/N	Social Security number	Date of birth Month	Day	Year	Sex M/F	U.S. Citizen Y/N	Race ①	Relation to you (son, daughter, grandson, other)

①Race information DOES NOT have to be given. If you choose to do so, use the following codes: 1=White; 2=Black; 3=American Indian/Alaskan; 4=Asian; 5=Hispanic/Latino; 6=HI/Pacific Islander; 7=Hispanic/Latino & Other; 8=Multi-Race Not Hispanic; 9=Unknown.

2. Please list **parent(s)**, **non-parent caregiver(s)** or **step-parent(s)** who live in the home. Step-parent income **will not** be counted in determining eligibility for their step-children. Only the income of the parent(s) will be counted.

Name - First, Middle Initial, Last	Social Security number	Date of birth Month	Day	Year	Sex M/F	Relation to child(ren) (mom, dad, step-parent, grandmother, other)

You **DO NOT** have to give a Social Security number if you **ARE NOT** applying for LaCHIP. Children, if eligible, will still be enrolled even if we do not get this information. Your Social Security number(s) will **ONLY** be used to verify income.

Is there anyone else living in your home who wants to apply for Medicaid? ❑ Yes ❑ No

3. Is anyone pregnant **AND** applying for health coverage? ❑ Yes ❑ No If **Yes**, give us the following information. Name _____Best Estimate of Due Date _____

4. Does every child applying for LaCHIP live in Louisiana? ❑ Yes ❑ No

5. Has any child applying ever received LaCHIP or Medicaid in Louisiana? ❑ Yes ❑ No
If **Yes**, does any child applying still have a plastic Louisiana Medicaid ID card? ❑ Yes ❑ No
If **Yes**, who still has a plastic ID card? _____
(If you still have the ID card, it will be activated as soon as your application is approved. It can be used right away.)

6. Does anyone pay court ordered child support to someone outside of your home? ❑ Yes ❑ No (To get a deduction, send proof of how much, how often and the name and relationship of the person to whom payments are made.)

7. Does anyone pay for child care (or care for an adult with a disability) so someone can work or get training? ❑ Yes ❑ No If **Yes**, give us the following information.

Care giver's name, address, and phone number	Name of the person who pays for care	Who gets this care?	How much do **you** pay?	How often?
			$	

8. Does anyone applying for LaCHIP now have or did they recently have private health insurance that covers doctor and hospital visits? ❑ Yes ❑ No If **Yes**, give us the following information.

Insurance company name, address, and phone number	Group/ Policy #	Date(s) of coverage		Person(s) covered	Policy covers:		
		Begin	End		Circle All That Apply		
					Hospital	Doctor	Ambulance
					Maternity	Drugs	Dental

If you do not currently have health insurance, would you be able to get health insurance for you and/or your children through your employer **if** you paid a monthly premium? ❑ Yes ❑ No
If **Yes**, about how much do you think you would have to pay each month? _____ (In certain cases, LaCHIP or Medicaid may be able to pay you for your share of the premium.)

9. Does anyone work? ❑ Yes ❑ No (For **each** job, send copies of **pay check stubs** or other proof of earnings received in the most recent full calendar month.) Is anyone self-employed? ❑ Yes ❑ No (Send copies of the most recent federal tax form **with all** schedule attachments, OR other proof if you do not have tax forms.) Tell us below about EACH full-time job, part-time job, or business. Show income before any deductions - **NOT** take-home pay. Grandparents and other non-parent caregivers **DO NOT** have to provide this information.

A. Give us the name, address, and phone # of the company or person you work for OR B. Self-Employment information	Name of the person working	Amount paid per hour	Number of hours worked/week	How often do you get paid?
		$		
		$		

10. Does anyone get ANY other money each month, like the kinds listed below? ❑ Yes ❑ No If **Yes**, give us the following information. (Circle the kind of income source and send proof of this income. You **DO NOT** have to send proof of Social Security/SSI income or voluntary child support.)

Income source	Source name, address, and phone number	Who gets this money?	How much?	How often?
Social Security/SSI			$	
Child Support/Alimony			$	
Other (please be specific)			$	

11. Does anyone applying need LaCHIP to cover medical care or services received during the last 3 calendar months? ❑ Yes ❑ No If **Yes**, which months?_____
(For any of the **past** three months that you want to apply for LaCHIP, send proof of the income you received in that month.)

Rights and Responsibilities

- I declare that everyone who is applying for health insurance is a U.S. citizen or is in this country legally.
- The information I give on this form is true and correct to the best of my knowledge. I realize if I knowingly give information that isn't true OR if I knowingly withhold information and my child(ren) get health benefits for which they are not eligible, I can be lawfully punished for fraud and I may have to re-pay Medicaid for any medical bills which are paid incorrectly.
- I understand that the information I give about our situation will be checked. I agree to help do that and to let Medicaid get needed information from government agencies, employers, medical providers and other sources.
- I know that our Social Security numbers will only be used to get information from other government agencies to prove eligibility.
- I understand by accepting Medicaid/LaCHIP, I give the Department of Health and Hospitals the right to any medical support or payments from third parties who would be legally responsible for any medical services paid by Medicaid for my child(ren). I agree to release any medical information needed by the Medicaid Program or others for the purpose of paying or receiving payment of medical bills. I understand that this is required to get coverage and I agree to help in obtaining medical support and payments from anyone who is legally responsible.
- I understand that Medicaid will **only** make a referral to Child Support Enforcement for medical support upon my request.
- I agree to tell Medicaid within 10 days of the following changes: 1) If anyone receiving health coverage moves out of state; 2) Changes where we live or get our mail; and 3) Changes in other health insurance coverage.
- I can ask for a Fair Hearing if I think the decision made on my case is unfair, incorrect or being made too late.
- Medicaid can't discriminate because of race, color, sex, age, disability, religion, nationality or political belief. If I think they have, I can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1+800+368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 1349 Baton Rouge, LA 70821-1349.
- Information about WIC, KIDMED and other Medicaid services will be sent to me if we are eligible for Medicaid.

_____ _____
Signature of Applicant (Parent) or Authorized Representative Date

_____ _____
Signature of Agency or AC Representative, if applicable Date

Please MAIL this form as soon as possible to:
LaCHIP Processing Office
P.O. Box 91278
Baton Rouge, LA 70821-9278
OR
Fax the front and back page to 1+877+LA FAX US (523-2987), toll free